diagnosis: lesion in the orbit, aneurism of the carotid in the cavernous sinus, basal process, lesion of the cranial bones exercising pressure, peripheral affection, root lesion, cortical or supranuclear lesion. These were all easily excluded, chiefly on the ground of the definite anatomical distribution of the lesion, and the absence of involvement of other structures in the vicinity. The lesion in this case was, without doubt, a nuclear one, an isolated affection, limited to the nuclei of the nerves in question, that is the third and seventh, in other words, it is a chronic superior bulbar paralysis or chronic superior encephalitis. The peculiarities in the case to be especially noted are the unilateral symptoms and the long duration without complication. The possibility is granted that, if the process should extend to the bulb, its unilateral character would then disappear. SCHWAB.

ÉTAT APOPLECTIFORME, HEMIPLÉGIE ET AMBLYOPIE ALTERNES, CHEZ UN HYSTERIQUE. GENÈSE ET RÔLE DE L'IDÉE FIXE. (Apoplectiform Attack, with Hemiplegia and Crossed Amblyopia in an Hysterical Person. Beginning and Role of the Fixed Idea.) SCHERB (Archives Provinciales de Médecine, I, No. 5, pp. 329-339).

Scherb reports a case which is interesting because the hemiplegia came on without known cause, and simulated organic hemiplegia so closely that a very careful examination was necessary to establish its hysterical character.

The patient was a carpenter, 49 years of age. He was received into the hospital with a diagnosis of cerebral apoplexy. He was semi-comatose and did not reply to any question. There was a right hemiplegia. During the first night the patient tried to raise himself in bed, but fell back, as the right side was helpless. There was no vomiting and no sphincter trouble. The next day the patient was in a profound stupor and did not reply to any questions, although he would open his mouth when requested, but without projecting the tongue. The hemiplegia seemed to involve the face, as the labial folds were plainly deviated to the left. The patient's temperature was 37.8°, and 38° at night. The tongue appeared to deviate in the mouth. It was not coated, nor was the patient's face flushed or his respiration stertorous. There was no conjugate deviation of the head and the eyes; he did not look to the left toward the supposed lesion. There was an active fluttering of the eyelids. Associated with this right hemiplegia was an absolutely profound hemianesthesia of the same side, but extending only up to the neck. The anesthesia was complete to touch, pain, heat and cold. The sole of the foot, however, was sensible, and the patient moved the toes slightly when they were pricked. But the toes responded by flexion when pricked, showing that Babinski's symptom was not present. On the left side of the body there was a very lively hyperesthesia, which extended to the face. One very curious symptom present was that when the left arm, the one not paralyzed, was raised from the bed by anyone, it had a tendency to remain in that position, only falling after some seconds, a condition suggesting catalepsy. The urinalysis showed no albumin or sugar.

On the second day after admission the patient answered questions by signs with his left arm, and also made known his wants in the same manner. It was learned that the present condition began with a sudden loss of vision in the left eye, so marked that the physician who saw him at that time thought it was due to an embolus of the central artery of the retina. Then hemiplegia came on with the first appearance of the apoplectiform attack. On examining the left eye, the cornea and conjunctiva were found to be absolutely insensible. The eye reacted normally to light. The right knee-jerk was exaggerated, but not abrupt, while the left was normal. There were no reflexes present at the elbows or wrists. On the left side of the body some very distinct hysterogenic zones were found which provoked a state of spasm very intense. The temperature and pulse were now normal. The man now whispered some almost inarticulate words when questioned. The pharynx was found insensible on the left side, and there was also an anesthetic area around the blind eye. When the patient was lifted out of bed and forced to make an attempt at walking he presented a typical example of the gait Charcot has described under the name of *helcopodie*. The patient dragged his leg after him as if it were a strange body, of which he seemed to ignore the existence. He walked, hopping on his sound leg only, hardly resting the point of his paralyzed foot on the ground. At this time his wife said that 28 years prior to this attack the patient had received a bullet in the right side of the neck at the level of the ascending branch of the maxillary. This bullet escaped on the same side near the nose. It was thought to have cut some of the filaments of the inferior facial, and to have caused the paralysis of the right face. (This paralysis of the right face has persisted since the disappearance of the hemiplegia.) Since this injury the man has been taciturn, likes to be alone, talks very little, has no friends, and replies to his wife only in monosyllables. He has had rheumatic pains for some years, and lately they have been markedly severe in the right arm and leg.

Scherb discusses the various symptoms presented by the patient, and, giving his interpretation of each, concludes that the man was suffering from an hysterical hemiplegia affecting the right arm and leg, and that the deviation of the tongue to the left and the paresis of the right face were the results of the bullet wound received 28 years before.

The patient one night was given 5 centigrammes of methylene blue and told that if his urine was not blue the following morning he would be completely paralyzed. The next morning he got out of bed and walked. He showed the doctor his blue urine and smiled. The next morning the blindness in the left eye had disappeared, and also the anesthesia of the cornea and conjunctiva and the anesthetic area surrounding that eye. The aphonia persisted and he insisted by gestures that he could not talk, because of the bullet wound he had received. The writer concluded that the man had two fixed ideas: (1) That he could not talk because his tongue, he thought, was paralyzed, and (2) that he was not able to work because his right arm was useless, both of which ideas were groundless.

Scherb summarizes the symptoms establishing the diagnosis of hysteria as follows: (1) Right hemiplegia, with hemianesthesia arrested at the neck. No crossed amblyopia. The gait called *helcopodie* by Charcot. (2) Apoplectiform onset apparently, but with no rise of temperature, and no conjugate deviation. Fluttering of the eyelids, an important sign noticed by Charcot and Gilles de la Tourette as peculiar to hysterical apoplexy. (3) Aphonia, with anesthesia of the hyoid region. Whispering possible. (4) Left amaurosis, with a large periorbital area of anesthesia. (5) No sphincter trouble. No signs of organic contractures. Absence of Babinski's sign. (6) The disappearance of all symptoms except aphonia. (7) The mental condition of the patient.

BONAR.